Metropolitan Women's Group, LLC
Obstetrics and Gynecology

Yolande Robertson- Hackney, MD & Leslie Simmons, MD

PATIENT REGISTRATION

Patient Name: **Cell #:**

Address: **Work #:** **Home #:**

City: **State:** **Zip:** **Email:**

Date of Birth: **Social Security #:**

Marital Status: Single ☐ Married ☐ Never Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced ☐

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ Other _____ ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline **Language:** ☐ English ☐ Spanish ☐ Other _____

Spouse/Partner/Parent (Please Circle One)

Name: **Cell #:**

Address: **Work #:**

City: **State:** **Zip:** **Email:**

Date of Birth: **Social Security #:**

Emergency Contact (if different than Spouse/Partner/Parent)

Name: **Relationship:**

Home #: **Work #:** **Cell #:**

Pharmacy (All Prescriptions will be sent to Pharmacy Electronically) **Pharmacy:** **Phone #:** **Location:**

Primary Care: **Phone #:**

INSURANCE INFORMATION

Please list all insurance plans you are currently enrolled in. Failure to disclose all accurate and updated insurance information may result in your being responsible for payment in full for services rendered. _____ ***(Patient Initials).***
PLEASE NOTE: MWG DOES NOT SUBMIT CLAIMS TO SECONDARY INSURANCE.

Primary Insurance:

Subscriber's Name:

Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐

Employer:

Subscribers Social Security#: **Subscribers Birthdate:**

Group#: **ID#:**

OTHER INFORMATION

Contact Preference: ☐ Mail Primary Address Phone: ☐ Home ☐ Work ☐ Cell ☐ Email

Assignment and Release: I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I also understand that I am responsible for contacting MWG with any future changes to this information. Further, I authorize my insurance and/or government benefits to be paid directly to Metropolitan Women's Group, LLC, and understand that I am financially responsible for all charges or unpaid balances and due upon receipt of statement. A collection fee of 40% will be added to outstanding balances on accounts sent to collections.

_____ (Patient Signature) _____ (Date)

Metropolitan Women's Group, LLC

Yolande Robertson- Hackney, MD & Leslie Simmons, MD

ADMINISTRATIVE POLICIES & PATIENT RESPONSBILITY

ABOUT OUR PROVIDERS

Thank you for entrusting us to take part in your medical care! We are committed to providing you with high-quality affordable care. Our physicians provide state-of-the-art Obstetrics and Gynecological care. They are Board Certified in OB/GYN and have been practicing in the community since 2003. When you visit our office, our goal is for you to feel comfortable and receive the highest quality of care in a professional and friendly environment.

OFFICE HOURS

Greenbelt – Monday, **W**ednesday **&** **T**hursday 9am – 5pm;
Silver Spring – **T**uesday & Wednesday 9am– 5pm;
Germantown – Monday, **T**uesday **&** **T**hursday 9am-5pm

For your Convenience the office is staffed and phones are turned on from 9am-1pm every **F**riday. **F**or **P**ickups and inquirys.

NOTICE OF PRIVACY PRACTICE

Metropolitan Women's Group, LLC will provide you with a copy of the Notice of Privacy Practices under separate cover which describes how your medical information may be used, disclosed and/or how you can gain access to this information.

PATIENT BILL OF RIGHTS

Metropolitan Women's Group, LLC want our patients to have the best possible patient care experience. We want you to know your rights as a patient, your responsibility to yourself, your providers and other caregivers. We have developed these with the upmost concern and respect for all. Please see the Patient Bill of Rights posted in our patient waiting area.

APPOINTMENT REMINDERS & NO SHOW

Arrive 15 minutes prior to the time of your appointment. If you arrive late to your appointment, you may be asked to reschedule. All scheduled office appointments not cancelled within 24 hours prior to your appointment, subjected to a $50.00 fee. All scheduled hospital, surgery Center and/or in-office procedures not cancelled within 72 hours are subject to a $350.00 fee. It is the patients responsibility to make all pre-op appointments and obtain medical clearances prior to surgery. This serves as notice that repeat missed appointments may results in dismissal from the practice.

FINANCIAL RESPONSIBILITY

It is important for you to understand that you, as the patient, are ultimately responsible for payment of medical services you receive. Payment of your bill is part of your treatment of care. All payments, including co-pays, co-insurance and deductibles amounts are due at the time of service. This arrangement is part of your contract with your insurance company. Failure to collect co-payments and deductibles from patients can be considered a breach of contract. We accept cash, Visa, Mastercard, Discover or American Express; checks are not accepted. Understand that any charges denied or not coverage by your insurance company will become your responsibility. Accounts will be balanced bill after insurance and payment due upon receipt of statement. A collection fee of 40% will be added to outstanding balances on accounts sent to collections.

Patients **S**ignature:_____ **D**ate:_____

7701 Greenbelt, Road, Suite 503 ~ Greenbelt, MD 20770 ~ 301-503-0200 ~ 301-513-0555 (Fax)
2101 Medical Park Drive, Suite 211 ~ Silver Spring, MD 20901
19851 Observation Drive, Suite 201, Germantown, MD 20876

Metropolitan
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PROOF OF INSURANCE
All patients must complete our Patient Registration Form annually. We must obtain a copy of your valid Drivers license or state/federal issued photo ID, insurance card, and referral (if required). If you fail to provide us with the correct insurance information at the time of each visit you may be responsible for the balance of the claim.

PAST DUE BALANCES
Any balance more than 30 days old will be considered past due. Once the balance is past due, payment will be required before your next visit in the office. Failure to make payment on the past due balance before your next scheduled appointment may result in the cancellation of your appointment. Payment in full is due upon receipt of our statement. Accounts with remaining balances will be sent to an outside collection agency.

RETURNED CHECKS
Written checks at the time of your visit are not permitted. Written check made and mailed as payment on accounts balances and returned will be assessed a $50.00 fee. If the original check amount plus the returned check charge is not paid within 15 days your account will be transferred to a collection agency.

REQUEST FORMS & MEDICAL RECORDS
In order to cover the cost of preparation, there is a $35.00 fee for all form completion. We do not process forms on behalf of insurance companies or disability claims. There is a $10.00 fee for all computer generated forms. The fee for electronic medical record sent directly to your provider is waived. The fee for a hard copy of your record will be based on the size of your record. Applicable fees are per patient, per request and must be made in advance.

PRESCRIPTIONS
We ask that you request all refill medications at the time of your visit. All prescriptions will be sent to your designated pharmacy electronically. If you need a refill, notify your pharmacy. They will contact us directly. If an appointment is required prior to a refill, the pharmacy will notify you.

AFTER HOURS
We are available 24 hours a day for all emergent patient concerns and will be addressed with the appropriate urgency. Non-urgent calls will be addressed as soon as possible. For non-urgent questions, patients are encouraged to send a message to the provider through the patient portal. Messages will be answered within 48 hours.

MY QUEST PATIENT PORTAL
Once you've established yourself with our practice, you will need to create your online account with our patient portal. Once you create your log-in and password, you can connect with your provider through a convenient, safe and secure environment, review your lab results and in the near future, make payments online and/or may receive an occasional alert or important notification regarding our practice and/or an upcoming appointment. There is a $10.00 fee for a hard copy of your results/labs.

I have read, understand and agree to comply with the policy as stated above.

Patient's Name **Patient's Signature** **Date**

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METRPOLITAN WOMEN'S GROUP, LLC

NOTICE OF PRIVACY PRACTICES
Effective date April 13, 2003, Revised September 2013
As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

WHO WILL FOLLOW THIS NOTICE - This notice describes Metropolitan Women's Group, LLC Privacy Practices and those of:

- All employees of Metropolitan Women's Group, LLC
- All healthcare professionals authorized to enter healthcare information into your record
- All departments and offices of Metropolitan Women's Group, LLC
- All Business Associates

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we are required by law to:

- Make sure that medical information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect
- In the event your health information is breached, we are required to provide you with notice of the breach.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. The effective date of the Notice, as well as the date of the most recent revision, is listed at the top of every page. You may Effective Date of this Notice: 4/13/2003, Revised September 2013, request a copy of our most current Notice at any time. This document is included in all new patient packets and is available on the practice website.

B. **IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER:**

7701 Greenbelt Road, Suite #503, Greenbelt, MD 20770
301-513-0200

C. **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:**

The following categories describe the different ways in which we may use and disclose your IIHI.

1.Treatment - Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses, may use or disclose your IIHI in order to treat you or to assist others treatment. Additionally, we may

disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. **Payment** - Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations** - Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. **Appointment Reminders** - Our practice may use and disclose your IIHI to contact you for an appointment.
5. **Treatment Options** - Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services** - Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends** - Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. You may restrict sharing your health information with someone who is involved in your care.
8. **Disclosures Required By Law** - Our practice will use and disclose your IIHI when are we required to do so by federal, state or local law.
9. **Marketing** – We will obtain your authorization before we use or disclose your health information for marketing, except we may use your information to have a face-to-face discussion about a service or to provide you with a gift of nominal value.

D. **USE AND DISCLOSURE WE MAY MAKE WITHOUT YOUR SPECIFIC AUTHORIZATION:**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:
1. **Public Health Risks** - Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

☐ Maintaining vital records, such as births and deaths

☐ Reporting child abuse or neglect

☐ Preventing or controlling disease, injury or disability

☐ Notifying a person regarding potential exposure to a communicable disease

☐ Notifying a person regarding a potential risk for spreading or contracting a disease or condition

☐ Reporting reactions to drugs or problems with products or devices

☐ Notifying individuals if a product or device they may be using has been recalled

☐ Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence): however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

☐ Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2.**Health Oversight Activities** - Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings** - Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement** - We may release IIHI if asked to do so by a law enforcement official:
☐ Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
☐ Concerning a death we believe has resulted from criminal conduct
☐ Regarding criminal conduct at our offices
☐ In response to a warrant, summons, court order, subpoena or similar legal process

☐ To identify/locate a suspect, material witness, fugitive or missing person

☐ In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health or Safety** - Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
6. **Military** - Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
7. **National Security** - Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates** - Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
9. **Workers' Compensation** - Our practice may release your IIHI for workers' compensation and similar programs.
10. **Organ and Tissue Donation** - If you are an organ donor, we may release medical information to organization handling organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

E. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding the IIHI that we maintain about you:

1. **Right to Confidential Communication** - You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. For example, you can ask that we only contact you at work or by mail, or at another mailing address, beside your home address. We must accommodate your request, if it is reasonable. You are not required to provide us with an explanation as to the reason for your request. If you would like to receive copies of your medical information after your treatment, you will specify the method and location that information should be sent to you.
2. **Requesting Restrictions** - You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing. Your request must describe in a clear and concise fashion:
a. The information you wish restricted;
b. Whether you are requesting to limit our practice's use, disclosure or both; and
c. To whom you want the limits to apply

We are not required to agree to your request unless your request pertains to not disclosing health information to a health plan for payment or operations related to services you paid in full from out of pocket. If we do agree with your request, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. **Inspection and Copies** - You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment** - You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures** - All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures,

you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice -** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our privacy officer.

7. **Right to file a Complaint -** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our privacy officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures -** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer.

Yolande Robertson- Hackney, MD & Leslie Simmons, MD

METROPOLITAN WOMEN'S GROUP, LLC
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I _____, have received a copy of the Metropolitan Women's Group, LLC
(Patient's Name)

Notice Privacy Practices.

_____
Signature of Patient Date

_____
Patient's DOB

7701 Greenbelt, Road, Suite 503 ~ Greenbelt, MD 20770 ~ 301-503-0200 ~ 301-513-0555 (Fax)
8630 Fenton Street, Suite #122 ~ Silver Spring, MD 20910 ~ 301-585-0040
19851 Observation Drive, Suite #201 ~ Germantown, MD 20876 ~ 301-556-5040